Department of Medical Assistance Services
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http://www.dmas.virginia.gov

MEDICAID MEMO

TO: All Acute Care Facilities, All Providers, and Managed Care Organizations (MCOs) Participating in the Virginia Medical Assistance Program

FROM: Jennifer S. Lee, M.D., Director
Department of Medical Assistance Services (DMAS)

MEMO: Special

DATE: 6/18/2018

SUBJECT: Update to the Reimbursement Methodology for Long Acting Reversible Contraceptives (LARC) in an Inpatient Hospital for Members in Medicaid and FAMIS Fee-for-Service Programs and Managed Care Organizations– Effective for Dates of Service On or After July 1, 2018

The purpose of this memorandum is to inform providers effective for dates of service on or after July 1, 2018, DMAS is updating its current reimbursement methodology for immediate post-partum LARCs provided after delivery in inpatient hospitals in order to increase access to these devices. This change applies to Medicaid and FAMIS Fee-for-Service members as well as those Medicaid and FAMIS members enrolled in a Medicaid Managed Care Organization (MCO).

DMAS will reimburse the inpatient hospitals based on the current fee file office-setting rate rather than the EAPG rate up to actual charges. Providers are reminded that charges should not exceed acquisition cost including any volume or other discounts. The reimbursement will continue to be a separate payment and not included in the Diagnostic Related Group (DRG) reimbursed to the Facility. The fee file can be found at the following link: Procedure Fee Files & CPT Codes.

The billing process for the inpatient LARC insertion for both the facility and the Physician has not changed. The specific billing guidelines for both Fee for Service and the MCOs can be found in the DMAS Provider memo dated 12/1/2016 at the following link:
Long Acting Reversible Contraceptives (LARC) Payment in an Inpatient Hospital for Members in Medicaid and FAMIS Fee-for-Service Programs and Managed Care Organizations-Effective for Dates of Service on or after January 1, 2017.

DMAS expects that Medicaid Management Information System (MMIS) and MCO claim systems changes are expected be in place by September 1, 2018, and claims with dates of service on or after July 1, 2018 will be reprocessed under the new methodology. There will be no need to resubmit or adjust claims.

This update does not affect the Physicians billing for the LARC implanted or inserted in outpatient offices or outpatient hospital settings. Claims will continue to be reimbursed via the current billing methodology for office services or outpatient hospital.

LARC Device J Codes covered for separate facility reimbursement at inpatient hospitals are:

IUD:

- J7297 – Liletta
- J7298 – Mirena
- J7301 – Skyla
- J7300 – Paragard

Implant

- J7307 – Implanon/Nexplanon

Prior authorization will not be required for these LARCs

MAGELLAN BEHAVIORAL HEALTH OF VIRGINIA (Behavioral Health Services Administrator)

Providers of behavioral health services may check member eligibility, claims status, check status, service limits, and service authorizations by visiting www.MagellanHealth.com/Provider. If you have any questions regarding behavioral health services, service authorization, or enrollment and credentialing as a Medicaid behavioral health service provider please contact Magellan Behavioral Health of Virginia toll free at 1-800-424-4046 or by visiting www.magellanofvirginia.com or submitting questions to VAProviderQuestions@MagellanHealth.com.

MANAGED CARE PROGRAMS

Most Medicaid individuals are enrolled in one of the Department's managed care programs: Medallion 3.0, Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan/PACE provider may utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for-service individuals. For more information, please contact the
individual's managed care plan/PACE provider directly.

Contact information for managed care plans/PACE providers can be found on the DMAS website for each program as follows:

- Medallion 3.0:
  http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx
- Medallion 4.0:
  http:/www.dmas.virginia.gov/Content_pgs/medallion_4-home.aspx
- Commonwealth Coordinated Care Plus (CCC Plus):
  http://www.dmas.virginia.gov/Content_pgs/mltss-proinfo.aspx
- Program of All-Inclusive Care for the Elderly (PACE):
  http://www.dmas.virginia.gov/Content_atchs/ltc/PACE%20Sites%20in%20VA.pdf

COMMONWEALTH COORDINATED CARE PLUS

Commonwealth Coordinated Care Plus is a required managed long term services and supports program for individuals who are either 65 or older or meet eligibility requirements due to a disability. The program integrates medical, behavioral health, and long-term services and supports into one program and provides care coordination for members. The goal of this coordinated delivery system is to improve access, quality and efficiency. Please visit the website at: http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx.

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Conduent Government Healthcare Solutions Support Help desk toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

KEPRO PROVIDER PORTAL

Providers may access service authorization information including status via KEPRO's Provider Portal at http://dmas.kepro.com.

HELPLINE

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.

TO ALL MEDICAID PROVIDERS: PROVIDER APPEAL REQUEST FORM NOW AVAILABLE

There is now a form available on the DMAS website to assist providers in filing an appeal with the DMAS Appeals Division. The link to the page is http://www.dmas.virginia.gov/Content_pgs/appeal-home.aspx and the form can be accessed from there by clicking on, "Click here to download a Provider Appeal Request Form." The form is in PDF format and has fillable fields. It can either be filled out online and then printed or downloaded and saved to your business computer. It is designed to save you time and money by assisting you in supplying all of the necessary information to identify your area of concern and the basic facts associated with that concern. Once you complete the form, you can simply print it and attach any supporting documentation you wish, and send to the Appeals Division by means of the United States mail, courier or other hand delivery, facsimile, electronic mail, or electronic submission supported by the Agency.

PROVIDERS: NEW MEDICARE CARDS ARE COMING

CMS is removing Social Security Numbers from Medicare cards to help fight identity theft and safeguard taxpayer dollars. In previous messages, CMS has stated that you must be ready by April 2018 for the change from the Social Security Number based Health Insurance Claim Number to the randomly

generated Medicare Beneficiary Identifier (the new Medicare number). Up to now, CMS has referred to this work as the Social Security Number Removal Initiative (SSNRI). Moving forward, CMS will refer to this project as the New Medicare Card.

To help you find information quickly, CMS designed a new homepage linking you to the latest details, including how to talk to your Medicare patients about the new Medicare Card. Bookmark the New Medicare Card homepage and Provider webpage, and visit often, so you have the information you need to be ready by April 1st.

Providers (which includes fee for service, Medicaid Managed Care Organizations, and Commonwealth Coordinated Care Plus) may share the following information with members:

MEMBERS: NEW MEDICARE CARDS ARE COMING

Medicare will mail new Medicare cards between April 2018 and April 2019. Your new card will have a new Medicare Number that's unique to you, instead of your Social Security Number. This will help to protect your identity.

Additional information is available at the following link:
https://www.medicare.gov/forms-help-and-resources/your-medicare-card.html